DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 7463 (Rev. 10/01)

STATE OF WISCONSIN
Administrative Code Chapter 110
(608) 266-1568

EMS AMBULANCE OPERATIONAL PLAN

For Office Use Only	

Completion of this form is mandatory for licensure as an Ambulance Provider. Updating and maintaining a current operational plan with the Wisconsin Department of Health & Family Services is required under Administrative Rule Chapters HFS 110, HFS 111,HFS 112 and s. 146.50 and 146.55 Wis. Stats.

INSTRUCTIONS

- Complete all sections of this form
- Additional instructions can be found at www.dhfs.state.wi.us/EMS_IP/index.htm
- Obtain all signatures requested on the last two pages of this form
- Keep one copy for yourself
- Submit one copy to the address below
- Attach a copy of your certificate of insurance for medical malpractice or professional liability
- Attach a copy of a map of your primary service area

RETURN COMPLETED PLAN IN ELECTRONIC FORM TO

EMT BASIC: Nicky Anders andernj@dhfs.state.wi.us
EMT INTERMEDIATE: Deborah Crawford crawfdk@dhfs.state.wi.us
EMT PARAMEDIC: Terry Gonderzik gondetl@dhfs.state.wi.us

RETURN COMPLETED PLAN IN PRINT FORM TO

Division of Public Health
Bureau of Emergency Medical Services and Injury Prevention
PO Box 2659
Madison, WI 53701-2659

This plan is a (check one):

☐ New ☐ Upgrade of Service
☐ Revised ☐ Special Event

Describe change: (If upgrading the level of service or revising your service operational plan, briefly describe change here and make changes to the appropriate section(s) of your approved operational plan.

Provider Name: **Date Submitted:**

CHECK WHEN COMPLETE	TOPIC	CHECK WHEN COMPLETE	TOPIC	CHECK WHEN COMPLETE	TOPIC
	AMBULANCE PROVIDER		**OPERATIONS**		**EDUCATION**
☐	Ambulance Provider Information	☐	Provider Operation	☐	Training Center
☐	License Level	☐	Staffing Information		
☐	Provider Description	☐	Annual Responses		**INFECTION CONTROL**
☐	Primary Service Area Information	☐	Provider Coverage	☐	Infection Control
☐	Insurance Information	☐	Ambulance Reporting		
	ASSOCIATES		**AFFILIATES**		**DATA COLLECTION**
☐	Owner Information	☐	First Responder Interface	☐	Data Collection
☐	Ryan White Contact	☐	Mutual Aid Agreements		
☐	Medical Director				**PATIENT CARE**
☐	Director or Chief Operating Officer		**COMMUNICATIONS**	☐	Protocols
☐	WEMSIS Contact	☐	Radio		
☐	Training Officer	☐	Dispatch	☐	**SIGNATURE PAGE**
☐	Quality Assurance Officer		**TRANSPORTATION**		
☐	Medical Control Hospital	☐	Ambulance		

AMBULANCE PROVIDER

Ambulance Provider Information

Provider Name	Provider No.	FEIN

Address (where records are kept)

City	State	Zip Code	County	E-mail Address

Daytime Telephone No.	Other Telephone No.	Fax Telephone No.	Pager No.
( ) -	( ) -	( ) -	( ) -

Mailing Address (If different than above)

City	State	Zip Code	County

DEA Number if applicable	CLIA Waiver Number	CLIA Waiver Expiration Date

Service License Level (Check all that apply)

☐ First Responder without defibrillation	☐ EMT Intermediate	☐ Fix winged
☐ First Responder with defibrillation	☐ EMT Paramedic	☐ Ground
☐ EMT Basic	☐ 911 Responder	☐ Critical Care
☐ EMT Basic IV	☐ Interfacility	☐ Helicopter

Provider Description (Check all that apply)

Municipally Owned	**Private Non – Profit**	**Private For – Profit**
☐ Paid Fire Department	☐ Paid Fire Department	☐ Paid Fire Department
☐ Volunteer Fire Department	☐ Volunteer Fire Department	☐ Volunteer Fire Department
☐ Ambulance Only	☐ Ambulance Only	☐ Ambulance Only
☐ Hospital Based	☐ Hospital Based	☐ Hospital Based
☐ County/Hospital Based	☐ County/Hospital Based	☐ County/Hospital Based
☐ County Operated	☐ County Operated	☐ County Operated
☐ Public Safety Department	☐ Public Safety Department	☐ Public Safety Department
☐ Police Department	☐ Police Department	☐ Police Department
☐ Air Ambulance – Fixed Wing	☐ Air Ambulance – Fixed Wing	☐ Air Ambulance – Fixed Wing
☐ Air Ambulance – Helicopter	☐ Air Ambulance - Helicopter	☐ Air Ambulance - Helicopter

Primary Service Area Information

List the city, townships or villages you provide primary response.

Describe population and community characteristics.

Attach a copy of a map of your Primary Service Area.

Insurance Information

Professional and/or Medical Liability Insurance Provider Name	Policy No.	Expiration Date

Address

City	State	Zip Code
		-

Agent Name

Business Telephone No.	Fax No.
( ) -	( ) -

Attach a copy of your certificate of insurance.

How Does Your Service Provide Coverage 24 Hours Per Day, 7 Days Per Week? (Check all that apply)

- ☐ Full time paid with staff at station
- ☐ Full time paid with staff on call
- ☐ Paid per call with staff at station
- ☐ Paid per call with assigned duty roster
- ☐ Volunteer with assigned duty roster
- ☐ Auxiliary coverage only (i.e. Interfacility service, special events)
- ☐ Volunteer without assigned duty roster (Explain)

☐ Other (Explain)

ASSOCIATES INFORMATION

Owner Information

Owner Name

Mailing Address

City	State	Zip Code	County

Daytime Telephone No.	Home Telephone No.	Fax Telephone No.	Pager Telephone No.
( ) -	( ) -	( ) -	( )- -

E-mail address

Owner Name (if more than one owner)

Mailing Address

City	State	Zip-Code	County

Daytime Telephone No.	Home Telephone No.	Fax Telephone No.	Pager Telephone No.
( ) -	( ) -	( ) -	( ) -

E-mail Address

Director or Chief Operating Officer Information (Note this individual is the 24 hour / 7 day contact)

Director or Chief Operating Officer Name	EMT No.

Mailing Address

City	State	Zip Code	County

Daytime Telephone No.	Home Telephone No.	Fax Telephone No.	Pager Telephone No.
( ) -	( ) -	( ) -	( ) -

E-mail address

Medical Director Information

Medical Director Name

Mailing Address

City	State	Zip Code	County

Daytime Telephone No.	Home Telephone No.	Fax Telephone No.	Pager Telephone No.
( ) -	( ) -	( ) -	( ) -

E-mail Address	Wisconsin License No.

Medical Director Name (if more than one)

Mailing Address

City	State	Zip Code	County

Daytime Telephone No.	Home Telephone No.	Fax Telephone No.	Pager Telephone No.
( ) -	( ) -	( ) -	( ) -

E-mail Address	Wisconsin License No.

WEMSIS Contact Information

Contact Name

Address

City	State	Zip Code	County

Daytime Telephone No.	Home Telephone No.	Fax Telephone No.	Pager Telephone No.
( ) -	( ) -	( ) -	( ) -

E-mail address

Training Officer Information

Training Officer Name

Address

City	State	Zip Code	County

Daytime Telephone No.	Home Telephone No.	Fax Telephone No.	Pager Telephone No.
( ) -	( ) -	( ) -	( ) -

E-mail address

Ryan White Contact Information

Ryan White Contact Name

Mailing address

City	State	Zip Code	County

Daytime Telephone No	Home Telephone No.	Fax Telephone No.	Pager Telephone No.
( ) -	( ) -	( ) -	( ) -

E-mail address:

Quality Assurance officer Information

QA or CQI Coordinator Name

Address

City	State	Zip Code	County

Daytime Telephone No.	Home Telephone No.	Fax Telephone No.	Pager Telephone No.
( ) -	( ) -	( ) -	( ) -

E-mail address

Describe the method of data collection:

Medical Control Hospital Information

Medical Control Hospital Name

Address

City	State	Zip Code	County

Name of Contact Person

Daytime Telephone No.	Home Telephone No.	Fax Telephone No.	Pager Telephone No.
( ) -	( ) -	( ) -	( ) -

E-mail address

Physician(s) Authorized to Provide On-line Medical Direction

Name	Wisconsin License Number	Name	Wisconsin License Number

OPERATIONS

Provider Operation - Answer each of the following that apply

Number of full-time Paramedic's		Number of part-time paramedics	
Number of paid paramedics		Number of volunteer paramedics	
Number of full-time Intermediates		Number of part-time Intermediates	
Number of paid Intermediate's		Number of volunteer Intermediates	
Number of full-time EMT's		Number of part-time EMT's	
Number of paid EMT's		Number of volunteer EMT's	
Number of full-time Registered Nurses		Number of part-time Registered Nurses	
Number of paid Registered Nurses		Number of volunteer Registered Nurses	
Number of paid non-licensed personnel		Number of volunteer non-licensed personnel	

Full time paid	Part time paid	Volunteer	Total staff

Staffing Information (List individuals who should appear on a roster)

EMT/RN/PA/MD License number	Name	Address	City	State	Zip Code	CPR Expiration	ACLS Expiration

Continue to next page if necessary

EMT/RN/PA/MD License number	Name	Address	City	State	Zip Code	CPR Expiration	ACLS Expiration

Annual Ambulance Responses

Emergency transports	
Interfacility transports	
No transports	
Total responses per year	

DATA COLLECTION

Ambulance Run Reporting

Are you currently using WEMSIS?	☐ Yes ☐ No
Are you currently using the state ambulance reporting form?	☐ Yes ☐ No

Attach a copy of current run report if not using the state ambulance report form.

AFFILIATES

Interface With First Responder Groups

Name	Location	Written Agreement	AED
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No

Mutual Aid Agreements (written backup agreements, mutual aid, ALS intercept, tiered response)

Name	Describe	Name	Describe

Is the service part of a local/county or regional disaster plan? ☐ Yes ☐ No

Do you have a copy on file? ☐ Yes ☐ No

COMMUNICATIONS

Does each ambulance owned and operated by this service have two-way radio equipment operating on 155.340 MHz?
Yes ☐ No ☐

Does each ambulance owned and operated by this service have two-way radio equipment operating on 155.400 MHz? (ALS Only)
Yes ☐ No ☐

If no to any of the above questions, please explain.

Does each ambulance have wireless telephone?
Yes ☐ No ☐

Describe how citizens access EMS?

Describe how you are dispatched?

Describe how are area first responders dispatched?

Name of agency providing dispatch.

Does your dispatcher provide pre-arrival instruction? ☐ Yes ☐ No

TRANSPORTATION

List all ambulance vehicles used by this service

Local unit No.	VIN	Date of last DOT Inspection	Vehicle location	Year placed in service

EDUCATION

Training

Name of local EMT Training Center	
Other training center(s) used	

Describe the method(s) used for continuing education and competency.

INFECTION CONTROL

Infection Control Officer Name

Address

City	State	Zip Code	County

Daytime Telephone No.	Home Telephone No.	Fax Telephone No.	Pager Telephone No.
( ) -	( ) -	( ) -	( ) -

E-mail address

Do you have a written Exposure Control Plan for bloodborne and airborne exposures? ☐ Yes ☐ No

Do you have a copy available for all members to review? ☐ Yes ☐ No

PATIENT CARE PROTOCOLS

Attach a copy of all protocols used for treatment of patients.

DEPARTMENT OF HEALTH & FAMILY SERVICES
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DPH 7463 (Rev. 10/01)

STATE OF WISCONSIN
Bureau of EMS and Injury Prevention
Adm. Rule HFS110
(608) 266-1568

SIGNATURE PAGE TO ACCOMPANY FORM DPH7463

Name of Ambulance Service Provider	**Provider License Number**

OWNER/OPERATOR CERTIFICATION

1. I certify that the information submitted on form DPH 7463 is true and complete to the best of my knowledge. I further certify that the named ambulance service will operate in conformance with s. 146.50 and s. 146.55, Wisconsin Statutes and Chapters 110, 111, and/or 112 Wisconsin Administrative Code.
2. The ambulance service will comply with the specifications and standards of the Wisconsin statewide emergency medical services communications system.
3. The ambulance service will use the Department's ambulance report form or a copy of an alternative report form will be provided to the Department for review and approval before its use. All runs will be documented on this ambulance report form and all forms will be kept and distributed in compliance with Wisconsin Statutes and Administrative Codes pertaining to patient medical records.

Signature of Owner _____ Date Signed _____

MEDICAL DIRECTOR CERTIFICATION

I certify that I am willing to participate in the above named ambulance service's program and fulfill the responsibilities of medical director as described in this plan and to adhere to the requirements of Chapters 110, 111 and/or 112, Wisconsin Administrative Code. Additionally, I certify that the attached medical protocols for this ambulance service provider have been reviewed and approved by me.

Signature of Medical Director _____ Date Signed _____

QUALITY ASSURANCE CERTIFICATION

I certify that the ambulance service provider is willing to participate in a data collection program, collect EMS data and to submit that data to the Department as requested.

Signature of Quality Assurance Representative _____ Date Signed _____

TRAINING CENTER CERTIFICATION

I certify that this EMT Training Center is willing to participate in the above named ambulance services' program and fulfill the responsibilities and requirements as described in this plan and to adhere to the requirements of Chapters 110, 111 and/or 112, Wisconsin Administrative Code.

Signature of Training Center Representative _____ Date Signed _____

Name of Ambulance Service Provider | **Provider License Number**

MEDICAL CONTROL HOSPITAL CERTIFICATION

I certify that this hospital is willing to participate in the above named ambulance services' program, providing on-line medical direction by a Wisconsin licensed physician 24 hours/7 days per week. Additionally, I certify that the facility will fulfill the responsibilities of medical control facility as described in this plan and adhere to the requirements of Chapters 110, 111 and/or 112, Wisconsin Administrative Code.

Signature of Medical Control Hospital Representative | Date Signed

MEDICAL CONTROL HOSPITAL CERTIFICATION

I certify that this hospital is willing to participate in the above named ambulance services' program, providing on-line medical direction by a Wisconsin licensed physician 24 hours/7 days per week. Additionally, I certify that the facility will fulfill the responsibilities of medical control facility as described in this plan and adhere to the requirements of Chapters 110, 111 and/or 112, Wisconsin Administrative Code.

Signature of Medical Control Hospital Representative | Date Signed

RECEIVING HOSPITAL CERTIFICATION

I certify that this hospital is willing to participate in the above named ambulance services' program and fulfill the responsibilities of receiving hospital facility as described in this plan and to adhere to the requirements of Chapters 110, 111 and/or 112, Wisconsin Administrative Code.

Signature of Receiving Hospital Representative | Date Signed

RECEIVING HOSPITAL CERTIFICATION

I certify that this hospital is willing to participate in the above named ambulance services' program and fulfill the responsibilities of receiving hospital facility as described in this plan and to adhere to the requirements of Chapters 110, 111 and/or 112, Wisconsin Administrative Code.

Signature of Receiving Hospital Representative | Date Signed

- Enclose copies of evidence of any local commitment to the proposed program including letters of endorsement from local and regional medical, governmental and emergency medical service agencies and authorities.

Return completed report to: EMS Systems and Licensing Section, PO Box 2659, Madison, WI 53701-2659.